Flores Center for Family Counseling, Inc

Symptom Questionaire

Name:_____

Date: _____

Personal Notation:
This form is not a subsitute for a professional-psychological asssessment, rather it is a self-report checklist of symptoms, one has experienced in the past two weeks.

	None of the Time	Some of the Time	All of the Time
Problems Sleeping			
Problems Eating			
Problems Focusing/Concetrating			
Little Energy			
Sadness/Depression			
Nervousness/Anxiety			
Hurting Yourself			
Hurting Others			